55 U/L, FA 198 U/L. **Discussão:** Disfunções hepatobiliares correspondem a 10-40% das complicações da AF, atingindo mortalidade >40%. Dentre os diferenciais agudos destacam-se a crise hepática, sequestro hepático e colestase intra-hepática que se manifestam com dor abdominal em quadrante superior direito (QSD) e icterícia. Na crise hepática e sequestro hepático ocorre hepatomegalia dolorosa, com transaminases normais neste último. Há dilatação sinusoidal, aprisionamento de eritrócitos, colestase intra-hepática e plugs biliares, sendo incomum necrose em anatomopatológico. Neste presente relato, descrevemos o fenótipo clínico mais incomum, mas potencialmente fatal da hepatopatia da AF que é a colestase intra-hepática aguda, cuja fisiopatologia envolve a falcização generalizada dentro dos sinusóides, com isquemia resultante e lesão dos hepatócitos. A apresentação clínica pode ser crise falciforme hepática aguda com dor no QSD e febre. Icterícia marcante pode se desenvolver e há acentuada elevação das transaminases, podendo evoluir para insuficiência renal e coagulopatia. Diferencia-se por poder cursar com áreas de necrose e inflamação. O desfecho favorável depende do diagnóstico assertivo e da instituição terapêutica o mais precocemente possível. O tratamento inclui suporte transfusional, transfusão de troca e correção de coagulopatia. **Conclusão:** Alterações hepatobiliares podem ter alta letalidade, sendo seu diferencial desafiador: toxicidade medicamentosa, sobrecarga de ferro, hepatites virais, além da hipóxia inerente à própria doença. A avaliação requer atenção minuciosa do quadro clínico, laboratorial e radiológico. A biópsia hepática, por ser um exame invasivo e não isento de complicações graves, só deve ser realizada em casos selecionados. Embora o tratamento para complicações hepáticas agudas e crônicas ainda não esteja totalmente estabelecido, o diagnóstico precoce e a rápida instituição de medidas de suporte e de eritrocitoaférese nos casos mais graves, pode levar a um desfecho clínico favorável embora as lesões hepáticas causadas possam ser irreversíveis.

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CLINICAL CHARACTERISTICS OF A LARGE COHORT OF PATIENTS WITH PAROXYSMAL NOCTURNAL HEMOGLOBINURIA RECEIVING ANTI-COMPLEMENT TREATMENT IN BRAZIL: A MULTICENTRIC REAL-WORLD EVIDENCE.

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Introduction: Paroxysmal nocturnal hemoglobinuria (PNH) is characterized by acquired abnormalities in the PIG-A gene, leading to hemolytic anemia, a hypercoagulable state, and cytopenias. Complement inhibitors targeting C5 have transformed PNH management. This study assessed clinical characteristics and outcomes of complement inhibition therapy in PNH. Methods: Multiparametric flow cytometry identified 151 PNH patients from 1987 to 2022, categorized as classic PNH (group 1), PNH with another hematologic disease (group 2), or subclinical PNH (group 3). Clinical and laboratory data were collected pre- and post-treatment. Informed consent was obtained from all patients. **Results:** Of the 151 patients, 53% were male, and the median age at diagnosis was 34 years. The hemolytic group (n = 90, 60%) exhibited common symptoms: fatigue (88%), hemoglobinuria (60%), abdominal pain (40%), headaches (19%), and dysphagia (17%). Venous thromboembolism occurred in 21 cases (24%), abdominal thrombosis in 11 cases (12%), and arterial thrombosis in eight patients (9%). Acute renal injury requiring dialysis affected five hemolytic patients (6%), with eventual recovery. Anti-complement treatment was administered to the majority of hemolytic patients (n = 62, 69%) after a median time of 22 months. It significantly reduced intravascular hemolysis, improved anemia, and alleviated symptoms. Within six months, 92% achieved transfusion independence, and within a year, 88% reached a good response or better, according to the Severe Aplastic Anemia Working Party (SAAWP/EBMT) hematological repsonse criteria. Overall survival at six years was 92% for classical PNH, 75% for PNH with another hematologic disease, and 67% for subclinical PNH. Notably, treated patients had significantly higher overall survival compared to untreated individuals (100% vs. 41%, $p < 0.0001$). Discussion: Groups 1 and 2, representing hemolytic PNH, exhibited a higher prevalence of symptoms such as fatigue, abdominal pain, and anemia requiring transfusion support, similar to previously reported. In this study, we observed a lower frequency of venous or arterial thrombosis in hemolytic patients, and the incidence of renal dysfunction was lower than previously reported, with only five patients (6%) in the hemolytic group experiencing acute renal failure, and demonstrated renal function recovery after resolving the crisis. Here we present the largest series of anti-complement treatment patients in Brazil. Although most patients treated with eculizumab demonstrate a good response, in previous series about 25-35% of patients continue to experience anemia and require transfusions, and here, we observed better results: 92% of patients achieved transfusion avoidance, with an 88% transfusion avoidance rate within one year, wich is classified as a hematological good response. The five-year overall survival rates were 92%, 75%, and 67% in groups 1, 2, and 3, respectively. **Conclusions:** This study corroborates clinical characteristics and PNH subtype distributions found in previous research. Anti-complement treatment effectively controlled hemolysis, improved symptoms, and reduced complications. Lower thrombosis and chronic kidney disease rates, and better hematological responses to anti-complement treatment warrant further investigation in this cohort.

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